

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009242

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No. 1003

Registrar's No.

2128

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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4803-3K

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USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS, MISSOURI		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Kirkwood	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS 627 S. Geyer	
3. NAME OF DECEASED (Type or print) MABEL S. RAUSCHKOLB		4. DATE OF DEATH Month FEBRUARY Day 24 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Mo.	
13a. FATHER'S NAME George Hoffmann		14. NAME OF HUSBAND OR WIFE Capt. G. H. Rauschkolb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date) no		17. INFORMANT Mrs. Inez House	
18. CAUSE OF DEATH (Enter only one cause per item 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYELOGENOUS LEUKEMIA		INTERVAL BETWEEN ONSET AND DEATH 5 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 204.1		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE		20h. DATE OF DEATH	
21. I attended the deceased from 2/5/63 to 2/24/63 and last saw her alive on 2/24/63		Death occurred at 3:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE F. R. BRADLEY, M.D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 2/25/63		22d. LOCATION (City, town, or county) DesPeres, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 2-27-63	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Cemetery		23d. DATE RECD. BY LOCAL REG. FEB 26 1963	
24. FUNERAL DIRECTOR Bopp Chapel		25. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Francis J. [Signature]

Licensed Embalmer No. 4512

P. O. Address

Kirkwood, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.